FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040998

Facility Name: Manorcare at Wilmette

Address: 432 Poplar Drive (Number) Wilmette (City) 60091 (Zip Code)

County: Cook

Telephone Number: (847) 256-5000 **Fax #** (847) 256-0225

IDPA ID Number: 520886946019

Date of Initial License for Current Owners: 06-12-95

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Dekany **Telephone Number:** (419) 252-5740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/2003 to 05/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Barry Lazarus

(Title) Vice President - Reimbursement

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/2003 Ending: 05/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	80	Skilled (SNF)	80	29,280	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	80	TOTALS	80	29,280	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	10,375	8,728	6,414	25,517	8
9	SNF/PED					9
10	ICF	937			937	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,312	8,728	6,414	26,454	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.35%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/12/95

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/12/95 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 80 and days of care provided 4,336

Medicare Intermediary Care First of Maryland, Inc

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 12/31/2004 Fiscal Year: 05/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/2003 Ending: 05/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	211,968	19,910	3,697	235,575	1,406	236,981		236,981			1
2	Food Purchase		124,529		124,529		124,529	(433)	124,096			2
3	Housekeeping	95,798	12,895	6,610	115,303		115,303		115,303			3
4	Laundry		7,599	584	8,183		8,183		8,183			4
5	Heat and Other Utilities			94,567	94,567	5,125	99,692		99,692			5
6	Maintenance	28,801	14,803	49,486	93,090		93,090		93,090			6
7	Other (specify):* Med Waste			462	462		462		462			7
8	**TOTAL General Services**	336,567	179,736	155,406	671,709	6,531	678,240	(433)	677,807			8
	B. Health Care and Programs											
9	Medical Director			22,500	22,500		22,500		22,500			9
10	Nursing and Medical Records	1,402,800	73,960	54,363	1,531,123	30,232	1,561,355		1,561,355			10
10a	Therapy	214,070	2,240	24,121	240,431		240,431		240,431			10a
11	Activities	77,776	7,434	2,043	87,253		87,253		87,253			11
12	Social Services	23,752			23,752		23,752		23,752			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,718,398	83,634	103,027	1,905,059	30,232	1,935,291		1,935,291			16
	C. General Administration											
17	Administrative	71,801		246,290	318,091	(89,344)	228,747		228,747			17
18	Directors Fees											18
19	Professional Services			8,901	8,901		8,901	(8,901)				19
20	Dues, Fees, Subscriptions & Promotions			45,553	45,553		45,553	(4,088)	41,465			20
21	Clerical & General Office Expenses	197,179	41,418	42,658	281,255		281,255	(64,143)	217,112			21
22	Employee Benefits & Payroll Taxes			443,450	443,450	34,102	477,552		477,552			22
23	Inservice Training & Education			3,318	3,318		3,318		3,318			23
24	Travel and Seminar			7,979	7,979		7,979		7,979			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			92,336	92,336		92,336		92,336			26
27	Other (specify):*											27
28	**TOTAL General Administration**	268,980	41,418	890,485	1,200,883	(55,242)	1,145,641	(77,132)	1,068,509			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,323,945	304,788	1,148,918	3,777,651	(18,479)	3,759,172	(77,565)	3,681,607			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Manorcare at Wilmette #0040998 Report Period Beginning: 06/01/2003 Ending: 05/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			305,237	305,237	18,479	323,716		323,716			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14,001	14,001		14,001	2,570	16,571			32
33	Real Estate Taxes			240,366	240,366		240,366	47,505	287,871			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			5,333	5,333		5,333		5,333			35
36	Other (specify):*											36
37	**TOTAL Ownership**			564,937	564,937	18,479	583,416	50,075	633,491			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		112,169	7,367	119,536		119,536		119,536			39
40	Barber and Beauty Shops			8,821	8,821		8,821		8,821			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			43,920	43,920		43,920		43,920			42
43	Other (specify):* **IV Therapy Drugs**		31,817		31,817		31,817		31,817			43
44	**TOTAL Special Cost Centers**		143,986	60,108	204,094		204,094		204,094			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,323,945	448,774	1,773,963	4,546,682		4,546,682	(27,490)	4,519,192			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/2003 Ending: 05/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(433)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(41,495)	21		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	2,570	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,499)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(295)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,025)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(8,901)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(17,829)	21		24
25	Fund Raising, Advertising and Promotional	(4,088)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	47,505	33		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (27,490)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (27,490)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			$		47

STATE OF ILLINOIS

Manorcare at Wilmette

ID# 0040998

Report Period Beginning: 06/01/2003

Ending: 05/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare at Wilmette # 0040998 **Report Period Beginning:** 06/01/2003 **Ending:** 05/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(433)	0	0	0	0	0	0	0	0	0	0	(433)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(433)	0	0	0	0	0	0	0	0	0	0	(433)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(8,901)	0	0	0	0	0	0	0	0	0	0	(8,901)	19
20	Fees, Subscriptions & Promotions	(4,088)	0	0	0	0	0	0	0	0	0	0	(4,088)	20
21	Clerical & General Office Expenses	(64,143)	0	0	0	0	0	0	0	0	0	0	(64,143)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(77,132)	0	0	0	0	0	0	0	0	0	0	(77,132)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(77,565)	0	0	0	0	0	0	0	0	0	0	(77,565)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare at Wilmette # 0040998 **Report Period Beginning:** 06/01/2003 **Ending:** 05/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	2,570	0	0	0	0	0	0	0	0	0	0	2,570	32
33	Real Estate Taxes	47,505	0	0	0	0	0	0	0	0	0	0	47,505	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	50,075	0	0	0	0	0	0	0	0	0	0	50,075	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(27,490)	0	0	0	0	0	0	0	0	0	0	(27,490)	45

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/2003 Ending: 05/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Manor Care, Inc	100	Health Care & Retirement Corporation of America (See H.O. Cost Report)	Toledo, OH			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		See Page 8	Home Office Allocation	$ 246,290	HCR Manor Care Inc	100.00%	$ 246,290	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V		10a	Therapy Management	10,188	Heartland Management Services	100.00%	10,188		6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 256,478			$ 256,478	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/2003 Ending: 05/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/2003 Ending: 5/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HCR Manor Care, Inc
Street Address: 333 North Summit St
City / State / Zip Code: Toledo, OH 43604
Phone Number: (419) 252-5500
Fax Number: (419) 254-5494

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	2,402,993,349	369 Nurs Fac	$	$	4,278,823	$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	2,860,540,914	369 Nurs Fac	940,169	509,589	4,278,823	1,406	2
3	5	Utilities - Direct	Accumulated Cost	2,402,993,349	369 Nurs Fac	288,728		4,278,823	514	3
4	5	Utilities - Pooled	Accumulated Cost	2,860,540,914	369 Nurs Fac	3,082,391		4,278,823	4,611	4
5	10	Nursing - Direct	Accumulated Cost	2,402,993,349	369 Nurs Fac	11,758,547	7,451,541	4,278,823	20,938	5
6	10	Nursing - Pooled	Accumulated Cost	2,860,540,914	369 Nurs Fac	6,213,377	3,630,889	4,278,823	9,294	6
7	17	General & Admin - Direct	Accumulated Cost	2,402,993,349	369 Nurs Fac	17,137,345	15,146,077	4,278,823	30,515	7
8	17	General & Admin - Pooled	Accumulated Cost	2,860,540,914	369 Nurs Fac	84,524,208	36,356,103	4,278,823	126,432	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,402,993,349	369 Nurs Fac	4,283,731		4,278,823	7,628	9
10	22	Employee Benefits - Pooled	Accumulated Cost	2,860,540,914	369 Nurs Fac	17,698,741		4,278,823	26,474	10
11	30	Depreciation - Direct	Accumulated Cost	2,402,993,349	369 Nurs Fac			4,278,823	0	11
12	30	Depreciation - Pooled	Accumulated Cost	2,860,540,914	369 Nurs Fac	12,354,014		4,278,823	18,479	12
13										13
14	32	Interest				11,412,188				14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 169,693,439	$ 63,094,199		$ 246,291	25

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/2003 Ending: 05/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	National City Bank						$ 223,000	$ 223,000			$ 13,993	1
2												2
3												3
4												4
5								Interest Income			2,578	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 223,000	$ 223,000			$ 16,571	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 223,000	$ 223,000			$ 16,571	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Manorcare at Wilmette # 0040998 **Report Period Beginning:** 06/01/2003 **Ending:** 05/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	185,463	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	232,968	2
3. Under or (over) accrual (line 2 minus line 1).	$	47,505	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	232,968	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	7,398	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	287,871	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	183,278	8
	2000	212,982	9
	2001	221,805	10
	2002	199,564	11
	2003	232,968	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manorcare at Wilmette COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040998

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

TELEPHONE (419) 252-5740 FAX #: (419) 254-5495

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05-34-121-041-0000	See Attached	$ 6,620.88	$ 6,620.88
2.	05-34-121-042-0000	See Attached	$ 3,752.75	$ 3,752.75
3.	05-34-121-048-0000	See Attached	$ 7,955.83	$ 7,955.83
4.	05-34-121-050-0000	See Attached	$ 5,679.88	$ 5,679.88
5.	05-34-121-051-0000	See Attached	$ 6,304.77	$ 6,304.77
6.	05-34-121-056-0000	See Attached	$ 193,909.15	$ 193,909.15
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 224,223.26	$ 224,223.26

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/2003 Ending: 05/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,881 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 3

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1995	$ 500,819	1
2					2
3	TOTALS			$ 500,819	3

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/2003 Ending: 05/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	80		1995	1969	$ 661,737	$ 108,418		$ 108,418	$	$ 947,570	4
5	CR 5/31/03 AUDIT ADJ		1995		3,635,000						5
6	CR 5/31/03 AUDIT ADJ		1995		40,000						6
7	CIP (59 BED ADDITION)		2004		547,137						7
8											8
	Improvement Type**										
9	BUILDING IMPROVEMENTS (Current Year Depreciation)										9
10				1983	7,273	105,164		105,164		619,800	10
11				1985	17,043						11
12				1988	1,961						12
13				1989	7,178						13
14				1990	20,800						14
15				1991	2,428						15
16				1992	34,209						16
17				1993	55,467						17
18	INSTALL GARBAGE DISPOSAL/EJECTORS			1995	1,726						18
19	STORAGE TANKS			1995	7,303						19
20	PAINTING			1995	2,355						20
21	FLOOR/WALL TILE			1995	1,643						21
22	VERTICLE VESSELS			1995	21,838						22
23	CARPET CLEANING			1996	1,197						23
24	CAPITALIZED LABOR			1996	4,074						24
25	CR 5/31/99 AUDIT ADJ			1996	(4,074)						25
26	SIGN			1996	162						26
27	ELECTRICAL			1996	181,279						27
28	GENERAL REQUIREMENTS			1996	110,589						28
29	FLOORING/CEILING			1996	75,391						29
30	ARCHITECT/ENGINEER/LEGAL FEES			1996	52,531						30
31	CR 5/31/99 AUDIT ADJ			1996	(16,232)						31
32	CARPENTRY/MASONRY			1996	35,295						32
33	MILLWORK			1996	17,943						33
34	DOOR & WINDOW FRAMES			1996	26,753						34
35	FINISH STUD/DRYWALL			1996	8,964						35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/2003 Ending: 05/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	PAINTING/WALLCOVERINGS	1996	$ 28,690	$		$	$	$	37
38	PLUMBING	1996	63,189						38
39	HVAC	1996	22,253						39
40	CORNER GUARDS	1996	4,423						40
41	NURSE CALL STATION	1996	32,513						41
42	LIGHTING	1996	15,386						42
43	PERMITS	1996	4,646						43
44	CORPORATE OVERHEAD	1996	86,993						44
45	CR 5/31/99 AUDIT ADJ	1996	(86,993)						45
46	TRAVEL/DELIVERY	1996	13,507						46
47	SIGNS	1996	2,875						47
48	KICKPLATES	1996	1,697						48
49	CABLE/WIRING	1996	2,218						49
50	CARPET	1996	37,911						50
51	WALLCOVERINGS	1996	30,453						51
52	NEW COIL	1996	6,413						52
53	PIPING/INSULATION	1996	10,765						53
54	PUMP UPGRADE	1996	2,639						54
55	RANGE GUARD	1996	1,649						55
56	NURSE CALL SYSTEM	1997	7,208						56
57	ARCHITECT/ENGINEER FEES	1997	3,491						57
58	GENERAL CONTRACTOR	1997	21,640						58
59	FURNISH & INSTALL HEATER	1997	5,109						59
60	REPLACE DOORS/ALARM	1997	2,957						60
61	REPLACE WATER LINE	1997	2,423						61
62	CORPORATE OVERHEAD	1997	10,516						62
63	CR 5/31/99 AUDIT ADJ	1997	(10,516)						63
64	SITE PREP/LANDSCAPE	1997	11,180						64
65	FLOORING	1997	916						65
66	ROOFTOP A/C	1997	39,990						66
67	FACILITY PLAN ALLOC	1997	5,964						67
68	CR 5/31/99 AUDIT ADJ	1997	(5,964)						68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,935,111	$ 213,582		$ 213,582	$	$ 1,567,370	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/2003 Ending: 05/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,935,111	$ 213,582		$ 213,582	$	$ 1,567,370	1
2	INSTALL NEW SUNROOM	1997	59,481						2
3	ASBESTOS REMOVAL	1997	19,675						3
4	ELECTRICAL	1997	4,156						4
5	ROOF WORK	1997	1,129						5
6	VINYL SHED	1997	803						6
7	ELECTRICAL	1998	17,790						7
8	PAINTING/ROOF/SIDING/CONCRETE	1998	20,304						8
9	BEAMS/STEEL	1998	4,320						9
10	CARPENTRY	1998	4,532						10
11	GENERAL CONTRACTOR FEES	1998	4,416						11
12	CARPET	1998	4,767						12
13	REMOVE & INSTALL DIFUSERS/DUCTS	1998	1,865						13
14	INSTALL DOORS	1998	4,466						14
15	CORPORATE OVERHEAD	1998	1,651						15
16	CR 5/31/99 AUDIT ADJ	1998	(1,651)						16
17	ENIGNEER/ARCHITECT FEES	1998	1,539						17
18	PLUMBING	1998	11,963						18
19	ELECTRICAL	1998	4,659						19
20	DEVELOPERS	1998	5,555						20
21	HVAC	1998	9,751						21
22	SIGN	1998	14,116						22
23	ROOFING	1998	3,725						23
24	PAVING	1998	17,975						24
25	PAINTING/WALLCOVERING	1999	1,418						25
26	FLOORING/CEILING	1999	3,964						26
27	HVAC	1999	6,727						27
28	DOOR/WINDOW	1999	2,938						28
29	ROOFING	1999	6,915						29
30	ARCHITECT	1999	15,472						30
31	KICKPLATES, HANDRAILS	1999	2,938						31
32	REMOVE OLD BOILER	1999	980						32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,193,450	$ 213,582		$ 213,582	$	$ 1,567,370	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/2003 Ending: 05/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,193,450	$ 213,582		$ 213,582	$	$ 1,567,370	1
2	BUILDING DECORATIONS	1999	4,680						2
3	A/C UPGRADE	1999	17,360						3
4	BOILER CONTROLS	1999	23,650						4
5	ENGINEERING SERVICE	1999	779						5
6	VWC RES RMS/CORRIDORS	2000	8,025						6
7	ACCESS PANEL/AC UNIT	2000	520						7
8	AIR CONDITIONING UNIT	2000	4,121						8
9	ROOF REPAIRS	2000	1,065						9
10	EVELATOR UPGRADE	2000	590						10
11	CIRCUIT BOARD - FIRE ALARM	2000	2,461						11
12	ROOF INSPECTION	2001	650						12
13	INJECTOR PUMP	2001	2,697						13
14	FREIGHT ON CARPET	2001	316						14
15	CARPET	2001	6,426						15
16	FREIGHT ON CARPET	2001	55						16
17	CARPET	2001	2,790						17
18	CARPET	2001	2,141						18
19	FAN COIL UNITS	2001	41,483						19
20	CARPET	2001	2,374						20
21	ROOF	2001	4,086						21
22	ROOFING	2001	7,151						22
23	ROOF	2001	1,800						23
24	WINDOWS	2002	15,000						24
25	ROOF	2002	1,886						25
26	RENOVATION-OVERHEAD & INTEREST	2002	4,258						26
27	CR 5/31/03 AUDIT ADJ	2002	(4,258)						27
28	RENOVATION-GENERAL CONST & ELECT	2002	55,642						28
29	RENOVATION-CARPET	2002	13,724						29
30	STAINLESS STEEL WALLCOVER	2002	6,780						30
31	BOLLARDS AROUND COOLING TOWERS	2002	3,386						31
32	WINDOWS	2002	14,606						32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,439,692	$ 213,582		$ 213,582	$	$ 1,567,370	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/2003 Ending: 05/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 6,439,692	$ 213,582		$ 213,582	$	$ 1,567,370	1
2	DOUBLE DOORS	2002	3,985						2
3	CARPET	2002	770						3
4	FREIGHT ON CARPET	2002	103						4
5	ROOF	2002	6,130						5
6	ROOF	2002	3,065						6
7	ROOF	2002	2,680						7
8	INSTALL CARPET	2002	458						8
9	INSTALL THREE DRAINS	2003	1,341						9
10	METAL STEEL DOOR	2003	1,000						10
11	METAL STEEL DOOR	2003	1,890						11
12	ARCHITECTURAL ENGINEERING	2003	602						12
13	ARCHITECTURAL ENGINEERING	2003	1,101						13
14	CARPET	2003	1,580						14
15	FREIGHT ON CARPET	2003	84						15
16	FREIGHT ON CARPET	2003	48						16
17	15 LIGHT FIXTURES	2003	3,600						17
18	BORDER	2003	629						18
19	BORDER	2003	131						19
20	VINYL WALL COVERING	2003	997						20
21	VINYL WALL COVERING	2003	581						21
22	BORDER	2003	179						22
23	BORDER	2003	149						23
24	VINYL WALL COVERING	2003	1,470						24
25	FREIGHT ON CARPET	2003	73						25
26	METAL DOOR AND INSTALLATION	2003	2,620						26
27	FLOORING AND VINYL WALL COV	2003	25,902						27
28	ARTWORK	2004	2,283						28
29	FREIGHT ON WINDOW TREATMENT	2004	97						29
30	CARPET	2004	1,580						30
31	FLOORING AND VINYL WALL COV	2004	400						31
32	CASH REICEPT FOR CARPET	2004	(1,580)						32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,503,639	$ 213,582		$ 213,582	$	$ 1,567,370	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/2003 Ending: 05/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,091,786	$ 91,655	$ 91,655	$		$ 915,733	71
72	Current Year Purchases	53,612						72
73	Fully Depreciated Assets							73
74	H/O ALLOCATION			18,479	18,479			74
75	TOTALS	$ 1,145,398	$ 91,655	$ 110,134	$ 18,479		$ 915,733	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,149,856	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 305,237	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 323,716	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 18,479	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,483,103	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	59 Bed Addition	$ 547,137	92
93			93
94			94
95		$ 547,137	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 5,333 Description: O2 Concentrators,Wheelchairs,Gerichairs,Elect Beds, Etc
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/2003 Ending: 05/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	2145 hrs	$ 59,951	161	$ 4,020	$ 272	2,306	$ 64,243	1
2	Licensed Speech and Language Development Therapist	10a	1397 hrs	39,042	211	5,287	714	1,608	45,043	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	4117 hrs	115,077	593	14,814	1,254	4,710	131,145	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				112,169		112,169	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): P/S - Lab	10,Col 3, 39				7,367			7,367	13
14	TOTAL			$ 214,070	965	$ 31,488	$ 114,409	8,624	$ 359,967	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Manorcare at Wilmette # 0040998 **Report Period Beginning:** 06/01/2003 **Ending:** 05/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 05/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 9,407	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (29,332))	388,716		3
4	Supply Inventory (priced at)	4,408		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,156		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 404,687	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	500,819		13
14	Buildings, at Historical Cost	5,956,501		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,145,399		16
17	Accumulated Depreciation (book methods)	(2,483,103)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	547,137		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,666,753	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,071,440	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 34,310	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	225,153		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	232,968		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Expenses	37,277		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 529,708	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	223,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	414		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 223,414	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 753,122	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,318,318	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,071,440	$	48

***(See instructions.)**

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/2003 Ending: 05/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,472,120	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,472,120	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(25,427)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (25,427)	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	(128,375)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (128,375)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 5,318,318	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/2003 Ending: 05/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,993,342	1
2	Discounts and Allowances for all Levels	(1,260,836)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,732,506	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	612,973	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 612,973	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	433	12
13	Barber and Beauty Care	10,769	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	41,495	16
17	Sale of Drugs	118,884	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,091	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	3,674	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 178,346	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	(1,565)	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ (1,565)	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	(1,005)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (1,005)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,521,255	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	671,709	31
32	Health Care	1,905,059	32
33	General Administration	1,200,883	33
	B. Capital Expense		
34	Ownership	564,937	34
	C. Ancillary Expense		
35	Special Cost Centers	204,094	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,546,682	40
41	**Income before Income Taxes (line 30 minus line 40)****	(25,427)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (25,427)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/2003 Ending: 05/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,723	1,867	$ 62,287	$ 33.36	1
2	Assistant Director of Nursing	583	632	18,528	29.32	2
3	Registered Nurses	15,988	17,323	420,078	24.25	3
4	Licensed Practical Nurses	12,443	13,482	265,304	19.68	4
5	Nurse Aides & Orderlies	52,566	56,956	612,535	10.75	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	6,880	7,660	214,070	27.95	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,488	7,038	77,776	11.05	10
11	Social Service Workers	1,341	1,437	23,752	16.53	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,425	18,030	211,968	11.76	15
16	Dishwashers					16
17	Maintenance Workers	1,425	1,612	28,801	17.87	17
18	Housekeepers	8,164	8,839	95,798	10.84	18
19	Laundry					19
20	Administrator	2,172	2,172	71,801	33.06	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,820	12,173	197,179	16.20	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,672	1,808	24,068	13.31	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	138,690	151,029	$ 2,323,945 *	$ 15.39	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	22,500	Ln 9 Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 22,500		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,560	$ 37,830	Ln 10 Col 3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	1,560	$ 37,830		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Caren Perlmuter	Administrator	0	$ 71,801
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 71,801

B. Administrative - Other

Description	Amount
Home Office	$ 246,290
TOTAL (agree to Schedule V, line 17, col. 3)	$ 246,290
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Foote,Meyers, Meilke & Flowers	Legal	$ 8,901
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 8,901

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 57,790
Unemployment Compensation Insurance	30,195
FICA Taxes	177,899
Employee Health Insurance	155,908
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	11,355
Payroll Overhead Allocated	(1)
401 K	5,757
Tuition Prgm	4,263
Employee Uniforms	284
Home Office Allocation	34,102
TOTAL (agree to Schedule V, line 22, col.8)	$ 477,552

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 723
Advertising: Employee Recruitment	25,018
Health Care Worker Background Check	
(Indicate # of checks performed 115)	2,290
Dues & Subscriptions	302
Association Dues	3,663
Advertising	13,521
Public Relations	36
Less: Non-Allowable Association Dues	(1,129)
Less: Public Relations Expense	(36)
Non-allowable advertising	(2,923)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 41,465

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	7,954
Includes travel espense to the Home	
Office in Toledo, OH for regional	
meeting	
Seminar Expense	25
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,979

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/2003 Ending: 05/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/2003 Ending: 05/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $ 3663**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes $ 1129**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **33,418** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **43,920**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.